STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085034	A. BUILDING _____ B. WING _____	C 12/01/2010

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HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from November 17, 2010 through December 1, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred sixty-seven (167). The survey sample totaled forty-eight (48) residents.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility's policy, it was determined that the facility failed to make prompt efforts to resolve a grievance involving a missing feather pillow for one (R156) out of 48 sampled residents. Findings include: An interview with E7 (certified nursing assistant) on 11/22/10 revealed that R156 reported a missing feather pillow approximately two to three months ago and that this was communicated to the management staff at the facility. Interview with R156 on 11/22/10 confirmed that she had been missing a feather pillow and that the facility is willing to replace the missing pillow, however, she had no way to replace the missing pillow. Review of facility's policy titled "Resident	F 166	F 166 It is the practice of this facility to promptly resolve grievances that residents may have, including those with respect to the behavior of other residents. 1. On 11/24/10, the facility procured and replaced the missing pillow for Resident # 156. This was reported to the Survey Team on that date. 2. As noted, the facility currently has a policy titled "Resident Concerns/Grievances" that clearly defines that all concerns will be documented on the Resident Concern Form, and will be logged, investigated, resolved and follow-up reported to reporting party. The facility will continue with this policy. ONGOING 3. All Staff will be re inserviced on the proper reporting and use of the Resident Concern Form. 1/31/11 4. The Administrator and Admissions Director will meet on a weekly basis to review outstanding concerns to ensure the proper resolution. The day and time of this meeting will be noted on the facility's monthly meeting calander. As per policy, the Admissions Director will continue to maintain the log for concerns. ONGOING	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DSM | TITLE: ADMINISTRATOR | (X6) DATE: 1/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 Concerns/Grievances" documented that all concerns will be documented by the department head to whom it was reported to using the "Resident Concern/Compliment Form" and will be logged, investigated, resolved, and follow-up reported to the reporting party. An interview with E8 (Admissions Director) on 11/23/10 at approximately 1:22 PM revealed that she retains a log of missing items, however, she did not have any report of the missing pillow for this resident. On 11/23/10 at approximately 3 PM, the surveyor was informed by E1 (Administrator) that he became aware of the missing pillow on 11/1/10 during resident council meeting. It was his understanding that the resident was to procure a replacement pillow and the facility was to reimburse the resident. E1 confirmed that a "Resident Concern/Compliment Form" was not utilized to document this missing pillow per facility policy and that the facility had not followed up or ensured that the resident was able to get a new pillow.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		

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F 225	Continued From page 2 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that for one (R231) resident out of 48 residents sampled the facility failed to immediately notify the state agency of an injury of unknown origin and failed to have evidence of a thorough investigation. Findings include: R231 was admitted to the facility on 3/19/10 with diagnoses that included chronic pain secondary to paraplegia and depression.	F 225	F 225 It is the practice of this facility to report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin in accordance with State Law through established procedures and to thoroughly investigate the alleged violations and report the findings in accordance with State Law. 1. Resident # 231 was discharged from the facility on 4/22/10 to home. 2. All Staff will be inserviced on the proper procedures for reporting alleged violations involving mistreatment, neglect, abuse, or injuries of unknown origin in accordance with State Law. 1/31/11 3. All incident reports, including injuries of unknown origin will be reviewed at the facility's morning stand up meeting to ensure compliance with proper reporting procedures. The ADON will maintain a log of all incident reports and will investigate all injuries of unknown origin and report the findings in accordance with State Law. ONGOING 4. The QI/QA committee will review the incident report log at the facility's monthly QA&A meeting to ensure compliance with proper reporting and investigative procedures. ONGOING	

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F 225	Continued From page 3 On 4/8/10 at 10:45 PM the nurses notes for R231 documented "...Left foot slight edematous keeping elevated on pillow." On 4/9/10 an x-ray was completed for R231's left foot and ankle. The X-ray report revealed "Left foot There is a fracture involving both malleoli with mild angulation. There is associated soft tissue swelling. No foreign body is seen. Osteoporosis is present. There is no foot fracture but there is soft tissue swelling.." An interview was conducted with E2 (DON) on 11/23/10 at 1:00 PM revealed that there was no evidence of completion of a thorough investigation concerning R231's fracture of unknown origin. E2 continued to state that there was no evidence that the state agency was notified immediately of the R231's fracture of unknown origin.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that two (R135 and R13) out of 48 sampled residents did not have a call bell placed within reach to call for assistance. Findings include:	F 246		

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F 246	Continued From page 4 1. Observation on 11/18/10 at approximately 9:30 AM, R135 was sitting in a manual wheelchair in her room and asked the surveyor for the call bell. The surveyor observed R135's call bell clipped to the left upper side rail which was in a down position. R135 related that she has been sitting in her wheelchair since 7:30 AM that morning and she was unable to reach the call bell to call for assistance. E6 (Registered Nurse) was immediately made aware by the surveyor and E6 proceeded to place the call bell within R135's reach. E6 did confirm that R135 utilizes the call bell to request for assistance. 2. On 11/19/10 at 9:27 am R13 was observed in bed with a consumed breakfast tray on the over the bed table and call bell on the floor of the left side of the bed near the wall. At 9:29 am the call bell was on the floor and staff had entered the room and removed the breakfast tray and delivered a supplement drink. At 11:15 am the call bell remained in the same spot on the floor. At 1:30 PM an aide enter the room, repositioned R13, picked the call bell up from the floor and placed it in reach of the resident.	F 246	F 246 It is the practice of this facility to provide the residents with reasonable accommodations of individual needs and preferences. 1. Resident # R135 and # R13 have the ability to utilize the call bell. All residents are oriented at admission as to the proper use and operation of the call bell if they demonstrate the ability to use the call bell. 2. The Nursing Staff will be inserviced to ensure that those residents who demonstrate the ability to use the call bell have the call bell within reach to call for assistance. 1/31/11 3. Nursing Administration will conduct random audits weekly for a period of 2 months to ensure compliance with call bells in place for those residents who demonstrate the ability to use the call bell. 4. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		

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F 279	Continued From page 5 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that for two (R230 and R218) out of 48 residents sampled the facility failed to develop care plans based on an identified need based on the comprehensive assessment. Findings include: 1. R230 was admitted to the facility with diagnoses that included malignant neoplasm of bladder, anemia, anxiety, adenocarcenoma, large tumor in colon, vagina and possibly bladder, oral cancer, arthritis, and rectal/vaginal bleeding due to the large pelvic mass. R230 had a care plan for "ADL (activities of daily living) function/rehab potential self care deficient related to (area left blank) as evidence by (areas left blank). Goals: Resident will remain at current level of functioning x 90 days Interventions: 10/29/10 Ativan 0.5mg po (by mouth) or sl (sublingual) every 4 hours as needed". This	F 279		

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F 279	Continued From page 6 care plan was not filled out completely and specifically for R230. Review of the care plans revealed there was no care plan to address R230's anxiety/restlessness that required the use of Ativan. Review of care plans on 11/22/10 at 1:35 PM with E9 (LPN charge nurse) confirmed no care plans were developed for R230's diagnoses of cancer and the psychosocial aspect of dealing with her terminal condition or for her anxiety. The care plan for ADL's was not completed appropriately. Review of R230's care plans with E5 (RN unit manager) on 11/22/10 at 3:05 PM confirmed R230's care plans were not developed as indicated. However, E5 would develop care plans to address R230's missing and inappropriately written care plans for her terminal diagnoses of cancer and anxiety. E5 also stated she was going to complete R230s care plan for ADLs. 2. R218 was admitted to the facility with diagnoses that included cerebral vascular accident with left sided hemiparesis and dementia. R218's October 13, 2010 MDS stated she was totally dependent on staff for her ADLs. Observations made on 11/19/10-11/23/10 revealed staff providing complete care for R218. Review of R218's care plan revealed she was care planned for ADL Functional/Rehab potential ... deficit related to (left blank) as evidenced by decreased function, strength and endurance Current level of functioning: (left blank) Goal: Resident will remain at current level of functioning x 90 days.(no date) Interventions ...Set up supplies and encourage resident to do as much	F 279	F 279 It is the practice of this facility to develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet the residents needs. 1. Resident # R230 was discharged from the facility on 11/27/10. Prior to her discharge the care plan for ADLs was completed properly and care plans were developed for her terminal diagnosis of cancer and anxiety. 2. Resident # R218 care plan was completed properly and updated to accurately reflect measureable objectives and timetables based on a comprehensive assessment of her needs. 11/30/10 3. The facility will conduct an audit of all care plans to ensure that they contain measureable objectives and timetables and are completed correctly. 12/31/10 4. Nursing Administration will conduct random audits weekly for a period of 2 months to ensure compliance with proper completion of comprehensive care plans. 5. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	

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F 279	Continued From page 7 of care as possible. Provide supervision, cues and prompting as needed..." On 11/23/10 at 7:50 AM review of R218's care plan and observations made during the survey with E12 (LPN) confirmed R218's care plan was not correct and not based on a comprehensive assessment of her needs.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	Continued From page 8 Based on record review and interview, it was determined that the facility failed to ensure that five (R156, R94, R209, R212, and R188) out of 48 sampled residents' drug regimen was free from unnecessary drugs. The facility failed to monitor laboratory values for R156 and failed to do an AIMs test on R209. In addition, the facility failed to have an indication for the use of medications ordered by physicians for five (R156, R94, F209, F212, and F188) out of 48 residents in the survey sample. Findings include: 1a. Review of R156's November 2010 Physician's Orders Sheet (POS) revealed an order for Tegretol 200 mg. (milligram) by mouth every 8 hours for trigeminal neuralgia. In addition, Tegretol level every six months in January and July. Record review revealed the most recent Tegretol level was obtained on 2/4/10. An interview with E5 (LPN, Unit Manager) on 11/23/10 at 9:30 AM confirmed that the Tegretol level was not obtained six months after the February 2010 level. 1b. Review of R156's November 2010 POS noted R156 was ordered Baclofen 20 mg. po (by mouth) QID (four times a day), however, the order lacked an indication or diagnosis. Findings reviewed with E2 (DON) on 11/30/10 at approximately 3 PM. 2. R94 was originally admitted to the facility on 7/1/08 with diagnoses including hypertension, benign prostate hypertrophy, depression, chronic pain syndrome, and chronic renal insufficiency. Review of R94's November 2010 POS noted the following medications Celexa 40 mg., Cymbalta 30 mg., Flomax 0.4 mg., Metoprolol Succ ER 25 mg. and Mucinex 600 mg. The POS lacked an	F 329	F 329 It is the practice of this facility to ensure that each residents drug regimen is free from unnecessary drugs. 1. Resident # R209 was discharged from the facility on 11/29/10. 2. Resident # R212 was discharged from the facility on 12/7/10. 3. Resident # R156 had a Tegretol Level drawn on 11/24/10. The order for Baclofen was updated to include an indication and diagnosis. 12/3/10 4. Resident # R94 had the orders for Celexa, Cymbalta, Flomax, Metoprolol and Mucinex were updated to include indication and diagnosis. 5. Resident # R188 had the orders for Neurontin and Ultram updated to include indication and diagnosis. He no longer has an order for Flagyl. 12/3/10 6. The facility will review all residents with routine Tegretol orders to ensure proper therapeutic labs are drawn per orders. 1/31/10 7. The facility will review all residents on anti-psychotic medications to ensure AIMS testing has been completed. 1/31/10 8. The facility will review all medications orders to ensure indication and diagnosis are included. 1/31/10 9. Nursing Administration will conduct random audits weekly for a period of 2 months to ensure compliance with therapeutic labs for Tegretol, AIMS testing for anti-psychotic medications and proper indication and diagnosis for all medications. 10. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	

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F 329	Continued From page 9 indication of usage for the medications. Findings were reviewed with E2 on 11/30/10 at approximately 3 PM. 3a. R209 was admitted to the facility on 7/27/10 with diagnoses which included coronary artery disease, dyslipidemia, hypertension, Alzheimer's dementia, coronary artery bypass surgery, cardiac arrest, encephalopathy, gait dysfunction, and carotid artery stenosis. Review of the November 2010 POS revealed the following medications did not have a diagnosis included for indication of use; klonopin 0.25 mg in am and 0.5 mg at hs, lisinopril 2.5 mg daily, and synthroid 25 mcg at 6 am. An interview with the unit manager (E5) on 11/30/10 at 10:50 am confirmed that there was no diagnoses documented with the physician order for the above medications. 3b. R209 had a physician order dated 8/24/10 that initiated the use of the antipsychotic medication Seroquel 12.5 mg po qd for dementia with delusions. On 8/31/10 the physician increased the Seroquel to 25 mg hs and to keep at 12.5 mg in am. The facility policy for AIMs (abnormal involuntary movement) testing documented that the test should be completed when a resident is initially placed on an anti-psychotic drug and every six (6) months thereafter. Interviews on 11/29/10 @ 3 PM and 11/30/10 @ 2:17 PM with charge nurse (E9) revealed no evidence that completion of the AIMs test could be found. An interview with the unit manager (E5)	F 329		

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F 329	Continued From page 10 on 11/30/10 at 2:28 PM confirmed no AIMs test could be found as completed when the Seroquel was initiated. 4. R212 was admitted on 8/10/10 with diagnoses that included anemia, hypertension, stroke (CVA) diabetes, osteoporosis, COPD, rheumatoid arthritis, history of breast cancer, cerebral vascular disease, osteoarthritis, constipation, gastrointestinal reflux disease. The resident had a physician's order for the following medications that did not include a diagnosis for indication of use; metoprolol 12.5 mg q hs, forteo pen inject 20 mcg sq qd, zeserid 20 mg daily for 4 weeks then resume omeprazole stop dec 10th, spirvia 18 mcg via handihaler qd, and singular 10 mg qd. Review of the admission physician order sheet had metoprolol with a diagnosis of hypertension but this was not carried over to the subsequent physician order sheets (POS) and medication administration records (MARs) by pharmacy and not picked up in reconciliation. Interview with (E10) unit manager at 10:41 am confirmed that there were no diagnoses on the POS for the above medications. 5. R188 had diagnoses which included history of closed reduction of left hip, muscle weakness, hypertension, benign prostatic hypertrophy, spinal stenosis, Cdiff, lyme disease, anemia, vertigo, anxiety, back pain, and arthritis. Review of the November POS included the medications neurontin 100 mg tid, ultram 50 mg q 6 hours, and flagyl 500 mg tid for 14 days with no	F 329		

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F 329	Continued From page 11 diagnosis included to indicate use. An interview on 12/1/10 at 9:50 am with the unit manager (E11) confirmed the lack of diagnosis on the POS for the aforementioned medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that each resident's drug regimen was reviewed by the licensed pharmacist at lease once a month for one (R94) out of 48 sampled residents. In addition, the facility failed to ensure that irregularities for four (R156, R209, R212, and R188) out of 48 sampled residents were reported to the attending physician and director of nursing. Findings include: 1. Cross refer F329, example #2. Review of R94's monthly "Consultant Pharmacist Record of MRR (Medication Regime Review)" lacked evidence that for June 2010, the resident's medication regimen was reviewed. An interview with E4 (licensed pharmacist) on 11/23/10 at	F 428		

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	085034	A. BUILDING _____ B. WING _____	C 12/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HEALTHCARE & REHAB CTR	301 OCEAN VIEW BLVD LEWES, DE 19958

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F 428	Continued From page 12 approximately 2:20 PM confirmed the above review was not completed for the above month. 2. Cross refer F329, example #1. Review of R156's November 2010 Physician's Orders Sheet (POS) revealed an order for Tegretol 200 mg. (milligram) by mouth every 8 hours for trigeminal neuralgia. In addition, Tegretol level every six months in January and July. Record review revealed the most recent Tegretol level was obtained on 2/4/10. An interview with E5 (LPN, Unit Manager) on 11/23/10 at 9:30 AM confirmed that the Tegretol level was not obtained six months after the February 2010 level. Review of R156's "Consultant Pharmacist Record of MRR" for the months of 7/10, 8/10, 9/10, and 10/10 failed to identify above irregularity. An interview with E4 on 11/23/10 at 2:25 PM revealed the "nursing report" which noted the lack of the Tegretol level was communicated to the facility during the MRR reviews in the months September and October 2010 with the third notification during the November 2010 review. An interview with E2 (Director of Nursing) on 11/30/10 at approximately 11 AM revealed that the only report received was dated 11/18/10 which indicated that the Tegretol level was due in July 2010. R 156's November 2010 POS noted R156 was ordered Baclofen 20 mg. po (by mouth) QID (four times a day), however, the order lacked an indication or diagnosis. 3. Cross refer F329 Example #3. R209 November 2010 PoS included physician	F 428	F 428 It is the practice of this facility to have the drug regimen of each resident reviewed at least once a month by a licensed pharmacist. 1. Resident # R209 was discharged from the facility on 11/29/10. 2. Resident # R212 was discharged from the facility on 12/7/10. 3. Starting with the January 2011 Pharmacy Review, upon arrival the pharmacist will obtain a current resident roster from the facility D.O.N., as the pharmacist completes the reviews she will initial next to the resident name on the roster. Upon completion of the reviews, the pharmacist will return the roster to the D.O.N. who will review the list to determine completion of all residents. The D.O.N. will retain this completed roster in the pharmacy manual. 1/31/11 4. Resident # R156 had a Tegretol Level drawn on 11/24/10. The order for Baclofen was updated to include an indication and diagnosis. 5. Resident # R94 had the orders for Celexa, Cymbalta, Flomax, Metoprolol and Mucinex were updated to include indication and diagnosis. 12/3/10 6. Resident # R188 had the orders for Neurontin and Ultram updated to include indication and diagnosis. He no longer has an order for Flagyl. 12/3/10 7. The facility will review all residents with routine Tegretol orders to ensure proper therapeutic labs are drawn per orders. 1/31/10 8. The facility will review all residents on anti-psychotic medications to ensure AIMS testing has been completed. 1/31/10	

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F 428	Continued From page 13 orders for the following medications without a diagnosis for indication of use; klonopin 0.25 mg in am and 0.5 mg at hs, lisinopril 2.5 mg qd, synthroid 25 mcg qd at 6 am. Review of the consultant pharmacist reviews lacked documentation that this was identified during the pharmacy review. Interviews with E9, charge nurse on 11/29/10 and E5, unit manager on 11/30/10 confirmed there were no diagnoses for these medications. R209 had physician orders dated 8/24/10 for the anti-psychotic medication Seroquel 12.5 mg po qd for dementia with delusions. On 8/31/10 the physician increased the Seroquel to 25 mg hs keep am at 12.5 mg. There was no evidence that an AIMs test was completed when the medication was initiated. Review of the consultant pharmacist reviews lacked documentation that this was identified during the pharmacy review. Interviews with E9 on 11/29/10 and E5 on 11/30/10 confirmed there was not an AIMs test completed. 4. Cross refer F329 example #4. R212 was admitted to the facility on 8/10/10. The November PoS had orders for the following medications with diagnoses for indication of use; metoprolol 12.5 mg q hs, forteo pen inject 20 mcg sq qd, zeserid 20 mg daily for 4 weeks then resume omeprazole stop dec 10th spirvia 18 mcg via handihaler qd, and singular 10	F 428	9. The facility will review all medications orders to ensure indication and diagnosis are included. 1/31/10 10. Nursing Administration will conduct random audits weekly for a period of 2 months to ensure compliance with therapeutic labs for Tegretol, AIMS testing for anti-psychotic medications and proper indication and diagnosis for all medications. 11. The results of these random audits will be reported to the QI/QA committee. The committee will determine the need for further audits.	

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F 428	Continued From page 14 mg qd The monthly reviews by the consultant pharmacist failed to identify the lack of diagnosis for each of these physician ordered medications. The admission physician order sheet had metoprolol with a diagnosis of HTN but this was not carried onto monthly PoS by the pharmacy and this was not picked up in reconciliation by the consultant pharmacist. Interview with E10 unit manager at 10:41 am confirmed that there were no diagnoses for the above medications on the PoS. 5. Cross refer F329 example #5. Review of R188's November PoS included the medications neurontin 100 mg tid, ultram 50 mg q 6 hours, and flagyl 500 mg tid for 14 days with no diagnosis included to indicate use. Review of the pharmacy consultant documentation on the clinical record lacked evidence that the lack of diagnoses had been identified during the monthly reviews. An interview on 12/1/10 at 9:50 am with the unit manager E11 confirmed the lack of diagnosis on the PoS for the aforementioned medications. E11 also provided the November 2010 consultant pharmacist review that the facility had just received which included the request for a diagnosis for the use of neurontin.	F 428		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests	F 469		

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F 469	Continued From page 15 and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made in resident rooms, common areas and bathing areas throughout the survey, it was determined that the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents. Findings include: 1. Flies were observed in the facility on all units, on all days of the survey, and by all members of the survey team. Review of the pest control program indicated that flies were a part of the monthly monitoring and abatement program.	F 469	F 469 It is the practice of this facility to maintain an effective pest control program so that the facility is free of pests. 1. As noted, the facility currently has a monitoring and abatement program that includes flies. 2. The facility contacted the Pest Control Company currently under contract and scheduled a specific abatement treatment for flies. 1/15/11 3. The facility will continue with the additional abatement treatments for a period of three months. During that time the Maintenance Director will monitor the facility for the presence of flies in resident and non-resident areas. 4. At the end of the three month time period, the facility Administrator and Maintenance Director will decide if further additional treatments will continue.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: December 1, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint visit was conducted at this facility from November 17, 2010 through December 1, 2010. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred sixty-seven (167). The survey sample totaled forty-eight (48) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby**	

DSM Donald S. Bogan Administrator 1/12/11

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: December 1, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	adopted and incorporated by reference. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 12/1/10, F225, F246, F279, F329, F428 and F469. **Title 16 Chapter 11, 1121 Patient's Rights (8)** **Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 12/1/10, F166.	Cross Reference CMS 2567 to F225, F246, F279, F329, F428, F469 Cross Reference CMS 2567 to F166